IN THE DISTRICT COURT FOR THE STATE OF OKLAHOMA, CLEVELAND COUNTY

Anne Andreassen,

Plaintiff,

v.

Health Care Service Corporation, a Mutual Legal Reserve Company (operating as Blue Cross Blue Shield of Oklahoma)

Defendant.

Case No. CJ-21-150 (V)

STATE OF OKLAHOMA } S.S.
CLEVELAND COUNTY }
FILED
FEB 19 2021
In the office of the
Court Clerk MARILYN WILLIAMS

PETITION

Plaintiff, for her causes of action, alleges and states:

1. This is an action brought pursuant to 29 U.S.C § 1001, et. seq. (ERISA).

2. Defendant Health Care Services Corporation (HCSC) is headquartered in Chicago, Illinois, and issues and administers health care plans in several states, including Oklahoma; the employee welfare benefit plans (Plan) at issue in this lawsuit are operated by HCSC under the name Blue Cross Blue Shield of Oklahoma. HCSC has significant contacts in this state/county.

3. Plaintiff is a citizen of Cleveland County, Oklahoma.

4. The Court thus has jurisdiction pursuant to ERISA.

EXHIBIT
1

5. Defendant Health Care Services Corporation (HCSC) has violated its legal and benefit Plan-based duties to Plaintiff by refusing to pay certain health care benefits claims incurred by Plaintiff.

6. At relevant times, Plaintiff was covered by an employee welfare benefit policy interchangeably referred to as the plan or the policy (the Plan) issued and administered by defendant HCSC[1]. The plan provides for Defendant to pay for medical care and treatment (hereafter "benefits").

7. Under the terms of the policy, Defendant administered claims under the Plan and retained the sole authority to grant or deny benefits to applicants.

8. Defendant funds the Plan benefits.

9. Defendant both funds the Plan benefits and retains the sole authority to grant or deny benefits, thus Defendant has an inherent conflict of interest.

10. Due to the conflict of interest described above, this Court should consider Defendant's decision to deny disability benefits as an important factor during its review in determining the propriety of Defendant's denial of Plaintiff's benefits.

[1] Group # YO1594-YUK835024449. The Plan was amended in 2020, but apparently retained the same identifying number. Defendant has failed (refused?) to produce true copies of the Plan despite Plaintiff's lawful requests. Where necessary to clarify the issues, the Plan and related claims will be identified as "the 2019 Plan/claims" or "the 2020 plan/claims". Exhibits hereto are from documents in Plaintiff's possession, and are submitted in good faith as current best evidence, since Defendant has failed to provide the requested documents, including true copies of the Plan documents attached to this Petition. Plaintiff reserves the right to amend the allegations once Defendant complies with Plaintiff's requests for information (see Third Cause of Action).

11. Defendant has a fiduciary obligation to administer the Plan fairly and to furnish disability benefits according to the terms of the Plan.

FIRST CAUSE OF ACTION

12. Defendant denied and/or improperly discounted claims under the 2019 Plan for several procedures which were a medically necessary part of Plaintiff's cancer treatment. Subsequent to the denials, Plaintiff complied with all relevant administrative procedures regarding claims for the benefits at issue, and then complied with all administrative appellate requirements regarding the denial. Defendant's denial of benefits was in violation of relevant legal standards of review.

13 The benefit plan covering 2019 claims is attached in relevant part and marked as Exhibit 1. Specific plan provisions at issue in this matter include, but are not necessarily limited to, the following:

A. The Plan covers medically necessary claims, Ex. 1; the claims at issue were submitted pursuant to the direction of Plaintiff's physicians, and were medically necessary.

14. Defendant's denial of benefits is contrary to the benefit plan's express provisions and constitutes an abuse of discretion as well as a breach of Defendant's fiduciary and other ERISA-imposed duties owed to Plaintiff.

15. Despite Defendant's failure to respond to previous lawful requests for information (see third Cause of Action, below), Plaintiff timely appealed the denials of benefits. Defendant denied the appeal.

16. Plaintiff has thus exhausted her administrative remedies (or they are deemed exhausted by operation of law) and this action is thus timely filed.

17. As a result of defendant's actions, Plaintiff has been damaged in the amount of accrued and accruing benefits; Plaintiff has also incurred legal costs and attorney's fees.

SECOND CAUSE OF ACTION

18. Defendant denied and/or improperly discounted claims under the 2020 Plan for several procedures which were a medically necessary part of Plaintiff's cancer treatment. Subsequent to the denials, Plaintiff complied with all relevant administrative procedures regarding claims for the benefits at issue, and then complied with all administrative appellate requirements regarding the denial. Defendant's denial of benefits was in violation of relevant legal standards of review.

19. The amended benefit plan covering 2020 claims is attached and marked in relevant part as Plaintiff's Exhibit 2. Specific plan provisions at issue in this matter include, but are not necessarily limited to, the following:

A. The Plan covers medically necessary claims, Ex. 2; the claims at issue were submitted pursuant to the direction of Plaintiff's physicians, and were medically necessary.

20. Defendant's denial of benefits is contrary to the benefit plan's express provisions and constitutes an abuse of discretion as well as a breach of Defendant's fiduciary and other ERISA-imposed duties owed to Plaintiff.

21. Despite Defendant's failure to respond to previous lawful requests for information (see third Cause of Action, below), Plaintiff timely appealed the denials of benefits. Defendant denied the appeal.

22. Plaintiff has thus exhausted her administrative remedies (or they are deemed exhausted by operation of law) and this action is thus timely filed.

23. As a result of defendant's actions, Plaintiff has been damaged in the amount of accrued and accruing benefits; Plaintiff has also incurred legal costs and attorney's fees.

THIRD CAUSE OF ACTION

24. On October 6, 2021, Plaintiff requested Defendant provide a copy of all claims and benefit information pursuant to ERISA statutes and regulations, so that Plaintiff could review the basis or bases of Defendant's denial and submit an appeal so as to obtain a full and fair review as required

by law; this request covered both claims under the 2019 and 2020 versions of the Plan.

25. Defendant was delegated and/or assumed all duties of the plan administrator, as evidenced by Defendant's "Group Administration Document", Exhibit 3, which forms part of the express agreement for coverage between Defendant and the relevant employee benefit plan administrator and/or sponsor. These duties, were both expressly and implicitly delegated/assumed by Defendant, and include duties of disclosure as discussed in the following paragraph.

26. Defendant was under a duty to respond to this request within 30 days pursuant to 29 U.S.C § 1132 (c)(1)(B) and 29 C.F.R. § 2560.503-1 (g)(B)(h)(2) and specifically subsection (iii) therein which mandates that "a claimant shall be provided...all documents, records and other information relevant to a claim for benefits". These items are defined at paragraph (m)(8) of the referenced section as any items "relied upon in making the determination as well as documents submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination."

27. Defendant only partially complied (and even then well past the 30 day deadline) with the request relative to the 2019 claims and ignored the request relative to the 2020 claims, and this failure to provide requested

information is a violation of ERISA statutes and regulations as set forth below; Defendant's failure to respond has prejudiced Plaintiff.

PRAYERS FOR RELIEF

Plaintiff prays for relief as follows:

28. A declaration that Defendant breached its fiduciary duties under ERISA by denying medically necessary care, which was covered by the plan;

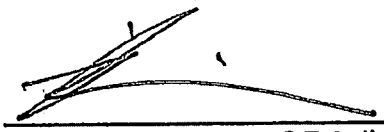
29. An order requiring Defendant to reimburse all incurred treatment costs as above-described arising from Defendant's violations of ERISA;

30. An order granting equitable restitution and other appropriate equitable monetary relief against Defendant;

31. Award plaintiff statutory damages of $110 per day pursuant to 29 U.S.C § 1132 (c)(1)(B) as amended by 29 C.F.R. § 2575.502 (c)(1).

32. An award of all other appropriate and equitable relief under ERISA, including but not limited to 29 U.S.C §1132 (a)(1)(b) and/or (a)(3), and costs, interest and attorney's fees.

Respectfully Submitted,

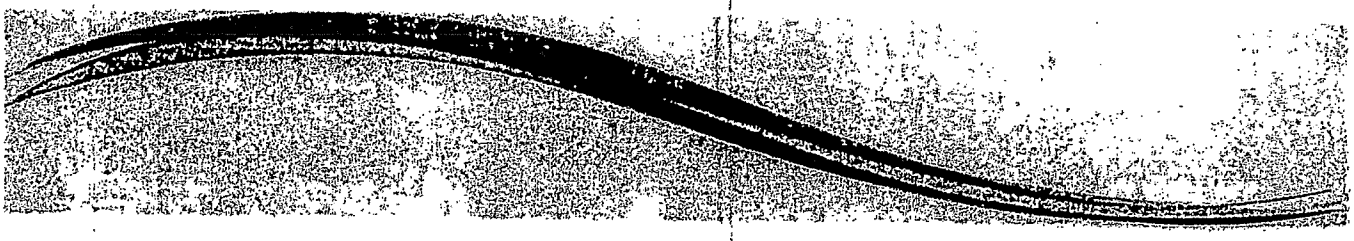


Roy S. Dickinson, OBA #13266
1408 Winding Ridge Rd.
Norman, OK 73072
(405) 321-3288
(405) 973-2204 (fax)
roy.d@coxinet.net

EXHIBIT 1

BCBSOK has omitted the Group Administrative Document attached to Plaintiff's original Petition as Exhibit 1 due to confidentiality

Your Health Care Benefit Program



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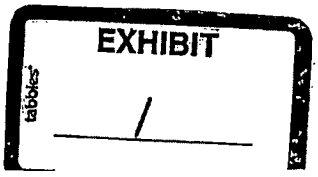

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Certificate Insert

Your Benefits under this program are subject to the following provisions:

DEDUCTIBLE	
Emergency Room Deductible	$100 for each visit to a Hospital emergency room.
Benefit Period Deductible	$500 per Benefit Period per Subscriber.
STOP-LOSS LIMIT	$5,000 per Benefit Period per Subscriber.

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

Table of Contents

Certificate

This Certificate is issued according to the terms of your Group Health Plan. It contains the principal provisions of the Group Contract and its ***Schedule of Benefits.*** In the event of conflict between the Contract and this Certificate, the terms of the Contract will prevail.

If a word or phrase starts with a capital letter, it has a special meaning in this Certificate . It is defined in the ***Definitions*** section, where used in the text, or it is a title.

Your Group has contracted with **Blue Cross and Blue Shield of Oklahoma** (called the Plan, we, us, or our) to provide the Benefits described in this Certificate. Blue Cross and Blue Shield of Oklahoma having issued a Group Contract to the Group, certifies that all persons who have:

- applied for coverage under the Contract;
- paid for the coverage;
- satisfied the conditions specified in the ***Eligibility, Enrollment, Changes and Termination*** section; and
- been approved by the Plan;

are covered by the Group Contract. Covered persons are called Subscribers (or you, your).

Beginning on your Effective Date, we agree to provide you the Benefits described in this Certificate .

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Comprehensive Health Care Services

This section lists the Covered Services under your health care program. **Please note that services must be Medically Necessary in order to be covered under this program.**

HOSPITAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Hospital or other Provider.

- **Bed and Board**

  Bed, board and general nursing service in:

  A room with two or more beds;

  A private room (private room allowance is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;

  A bed in a Special Care Unit which gives intensive care to the critically ill.

  Inpatient services are subject to the Precertification guidelines of this Certificate (see *"Important Information"*). If you fail to comply with these guidelines, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by $500, provided the Plan determines that Benefits are payable upon receipt of a claim.

- **Ancillary Services**

  Operating, delivery and treatment rooms;

  Prescribed drugs;

  Whole blood, blood processing and administration;

  Anesthesia supplies and services rendered by an employee of the Hospital or other Provider;

  Medical and surgical dressings, supplies, casts and splints;

  Oxygen;

  Subdermally implanted devices or appliances necessary for the improvement of physiological function;

  Diagnostic Services;

  Therapy Services.

  Benefits for Speech Therapy are limited to Inpatient services only.

- **Emergency Accident Care**

  Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.

- **Emergency Medical Care**

  Outpatient emergency Hospital services and supplies to treat a sudden and acute medical condition that requires prompt Medical Care.

- **Surgery**

  Hospital services and supplies for Outpatient Surgery furnished by an employee of the Hospital or other Provider other than the surgeon or assistant surgeon.

- **Routine Nursery Care**

  Inpatient Hospital Services for Routine Nursery Care of a newborn Subscriber.

  Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Certificate:

  - the infant will be considered as a Subscriber in its own right and will be entitled to the same Benefits as any other Subscriber under this Certificate; and
  - a separate Deductible will apply to the newborn's Hospital confinement.

Benefits are not provided for Routine Nursery Care for an infant born to a Dependent child.

SURGICAL/MEDICAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Physician or other Provider.

- **Surgery**

  Payment includes visits before and after Surgery.

  If an incidental procedure* is carried out at the same time as a more complex primary procedure, then Benefits will be payable for only the primary procedure. **Separate Benefits will not be payable for any incidental procedures performed at the same time.**

  When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:

  - the primary procedure; plus
  - 50% of the amount payable for each of the additional procedures had those procedures been performed alone.

  Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

  Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant surgeon only if determined Medically Necessary by the Plan.

- **Anesthesia**

  Administration of anesthesia by a Physician or other Provider who is not the surgeon or the assistant surgeon.

**A procedure carried out at the same time as a primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and, therefore, should not be reimbursed separately.*

- **Inpatient Medical Services**

Medical Care when you are an Inpatient for a condition not related to Surgery, pregnancy, or Mental Illness, except as specified.

Inpatient Medical Care Visits

Inpatient Medical Care visits are limited to one visit or other service per day by the attending Physician.

Intensive Medical Care

Constant Physician attendance and treatment when your condition requires it for a prolonged time.

Concurrent Care

- Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.
- If the nature of the illness or injury requires, care by two or more Physicians during one Hospital stay.

Consultation

Consultation by another Physician when requested by your attending Physician, **limited to one visit or other service per day for each consulting Physician.** Staff consultations required by Hospital rules are excluded.

Newborn Well Baby Care

Routine Nursery Care visits to examine a newborn Subscriber, limited to the first 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section. No additional Inpatient visits are covered for well baby care.

- **Outpatient Medical Services**

Outpatient Medical Care that is not related to Surgery, pregnancy, or Mental Illness, except as specified.

Emergency Accident Care

Treatment of accidental bodily injuries.

Emergency Medical Care

Treatment of a sudden and acute medical condition that requires prompt Medical Care.

Home, Office, and Other Outpatient Visits

Visits and consultation for the examination, diagnosis, and treatment of an injury or illness.

Preventive Care Services

Services performed by a Provider as "routine" or "screening" services, **limited to $300 per Benefit Period for Subscribers age 19 or older.** Routine or screening examinations which meet the guidelines for mandated Benefits, established by Oklahoma state law, shall not be included as Preventive Care Services, but shall be subject to the limitations specified elsewhere in this Certificate.

Unless specifically provided by Oklahoma state law, the following services are not included:

- Hearing or vision screening examinations;
- Medical supplies or equipment;
- Routine foot care.

Routine Gynecological/Obstetrical Examination and Pap Smear

Routine gynecological/obstetrical examination and Pap smear performed in the Physician's office, **limited to once each Benefit Period.**

Contraceptive Devices

Contraceptive devices which are:

- placed or prescribed by a Physician;
- intended primarily for the purpose of preventing human conception; and
- approved by the U.S. Food and Drug Administration as acceptable methods of contraception.

Prostate Cancer Screening

Annual screening for the early detection of prostate cancer in male Subscribers, including a prostate-specific antigen blood test and a digital rectal examination. **Benefits are limited to one screening exam per Benefit Period and shall not exceed $65 per screening.**

Colorectal Cancer Screening

Colorectal cancer examinations and laboratory tests for cancer screening for any nonsymptomatic Subscriber, in accordance with standard, accepted published medical practice guidelines.

Immunizations, limited to:

- Diphtheria , tetanus, and pertussis (whooping cough) vaccine (DTaP);
- Tetanus vaccine;
- Poliomyelitis vaccine;
- Measles virus vaccine;
- Mumps virus vaccine;
- German measles (rubella) vaccine;
- Measles, mumps, and rubella vaccine (MMR);
- Varicella (chicken pox) vaccine;
- Pneumonia vaccine;
- Pneumococcal vaccine;
- Haemophilus influenzae type b (Hib);
- Rotavirus vaccine, **limited to Subscribers under age 19;**
- Human papillovirus vaccine (HPV), **limited to Subscribers under age 19;**
- Hepatitis A and hepatitis B vaccine, **limited to Subscribers under age 19;**
- Meningococcal vaccine, **limited to Subscribers under age 19;**
- Any other immunization required for children by the Oklahoma State Board of Health.

Child Health Supervision Services

The periodic review of a child's physical and emotional status by a Physician or other Provider pursuant to a Physician's supervision, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

Child Health Supervision Services must be rendered during a periodic review, provided by or under the supervision of a single Physician during the course of one visit.

Child Health Supervision Services are limited to Subscribers under age 19.

Audiological Services

Audiological services and hearing aids, limited to:

- **One hearing aid per ear every 48 months for Subscribers up to age 18; and**
- **Up to four additional ear molds per Benefit Period for Subscribers up to two years of age.**

Hearing aids must be prescribed, filled and dispensed by a licensed audiologist.

Bone Density Testing

Bone density testing when ordered or performed by a Physician or other Provider. **Benefits are limited to $150 for each bone density test.**

OUTPATIENT DIAGNOSTIC SERVICES

- Radiology, Ultrasound and Nuclear Medicine

Radiological services include bilateral mammography screening (two view film study of each breast) for the presence of occult breast cancer, limited to:

one screening examination every five years for female Subscribers age 35 through 39; and

one *annual* screening examination for female Subscribers age 40 or older.

Benefits for *routine* Low-Dose Mammography shall be limited to $115 per screening.

- Laboratory and Pathology
- ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Plan

OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy
- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy and Occupational Therapy

Benefits for Outpatient Physical Therapy and Outpatient Occupational Therapy are limited to a combined maximum of 25 visits per Benefit Period per Subscriber.

Exclusions

This section lists what is not covered. We want to be sure that you do not expect Benefits that are not included in this Certificate. It also explains the Preexisting Condition provisions in your coverage.

WHAT IS NOT COVERED

Except as otherwise specifically stated in this Certificate, we do not provide Benefits for services, supplies or charges:

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which we determine are not Medically Necessary, except as specified.
- Received from other than a Provider.
- Which are in excess of the Allowable Charge, as determined by the Plan.
- Which the Plan determines are Experimental/Investigational in nature.
- For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.

  You agree to:

  - pursue your rights under the workers' compensation laws;
  - take no action prejudicing the rights and interests of the Plan; and
  - cooperate and furnish information and assistance the Plan requires to help enforce its rights.

  If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:

  - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
  - repay the Plan any money recovered from your employer or insurance carrier.
- To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- For any illness or injury suffered after the Subscriber's Effective Date as a result of war or act of war, declared or undeclared, when serving in the military or an auxiliary unit thereto.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:

  needed to repair conditions resulting from an accidental injury; or

  for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue .

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.

- Received from a member of your immediate family.
- Received before your Effective Date.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- Received after your coverage stops.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing , or for rest cures.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations , except as specified in the ***Comprehensive Health Care Services*** section.
- For reverse sterilization.
- For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:

  the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or

  for the improvement of the physiological functioning of a malformed body member.

  Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures .

- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:

severely disabled; or

eight years of age or under;

and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers up to age 18. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury.
- For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- For Prescription Drugs prescribed and used for cosmetic purposes.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:

  Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under; or

  Prescription Drug therapy (provided this Certificate includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD in Subscribers age 19 and under.

- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan-approved Provider.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under ***"Human Organ, Tissue and Bone Marrow Transplant Services"***.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high- or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, licensed clinical social worker or person with a master's degree in social work.
- For services rendered by licensed professional counselors, marital and family therapists or counselors or licensed drug and alcohol counselors.
- For services rendered by midwives.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Certificate.

We may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for Benefits under this Certificate. You must provide to us all documents needed to enforce our rights under this provision.

PREEXISTING CONDITION EXCLUSION

Your Benefits under this Certificate are subject to a Preexisting Condition Exclusion period. However, the Preexisting Condition Exclusion will only apply to you and/or a Dependent if the following conditions are met:

- **Six-month Look-back Rule**

  The Preexisting Condition Exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the Subscriber's Enrollment Date.

  In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.

  The six-month look-back period is based on the six-month "anniversary date" of the Enrollment Date.

- **Length of Preexisting Condition Exclusion Period**

  The exclusion period cannot extend for more than 12 months (18 months for Late Enrollees*) after the Enrollment Date. The 12-month or 18-month "look forward" period is also based on the anniversary date of the Enrollment Date.

- **Reduction of Preexisting Condition Exclusion Period by Prior Coverage**

  In general, the Preexisting Condition Exclusion period must be reduced by the individual's days of "Creditable Coverage" as of the Enrollment Date. Creditable Coverage includes coverage from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid. However, days of Creditable Coverage that occur before a Significant Break In Coverage (63 or more consecutive days) will not be counted in reducing the Preexisting Condition Exclusion period.

  In addition, the Preexisting Condition Exclusion period will be *waived* for an individual with prior Creditable Coverage through a Health Maintenance Organization, and who Enrolls under this Certificate without a Significant Break In Coverage.

- **Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children**

  A Preexisting Condition Exclusion cannot apply to pregnancy. In addition, a Preexisting Condition Exclusion period will not be applied to a newborn, an adopted child under age 18, or a child Placed for Adoption under age 18, if the child becomes covered within 31 days of birth, adoption, or Placement for Adoption.

- **Notice to Subscribers**

  The Plan may only impose a Preexisting Condition Exclusion with respect to a Subscriber by notifying the Subscriber, in writing, of the existence and terms of any Preexisting Condition Exclusion under the Plan and of the rights of the Subscriber to demonstrate Creditable Coverage. The Plan will assist the Subscriber in obtaining a Certificate of Coverage from any prior health plan or issuer, if necessary.

The Plan may, without waiving the above provisions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the above Preexisting Condition limitations. If it is later determined that the care and services are excluded from the Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Certificate. The Subscriber must provide the Plan with all documents it needs to enforce its rights under this provision.

* *See the **Definitions** section for an explanation of this term.*

General Provisions

This section tells:

- The Benefits to which you are entitled;
- How to get Benefits;
- Your relationship with Hospitals, Physicians, and other Providers;
- Your relationship with us;
- Coordination of Benefits when you have other coverage.

BENEFITS TO WHICH You ARE ENTITLED

We provide only the Benefits specified in this Certificate.

Only Subscribers are entitled to Benefits from us and they may not transfer their rights to Benefits to anyone else.

Benefits for Covered Services specified in this Certificate will be covered only for those Providers specified in this Certificate.

PRIOR APPROVAL

The Plan does not give prior approval or guarantee Benefits for any services through its Precertification process, or in any oral or written communication to Subscribers or other persons or entities requesting such information or approval.

NOTICE AND PROPERLY FILED CLAIM

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to you. Upon receipt of written notice, the Plan will furnish claim forms to you for submitting a Properly Filed Claim. If the forms are not furnished within 15 days after the Plan receives your notice, you can comply with the Properly Filed Claim requirements by forwarding to the Plan, within the time period set forth below, written proof covering the occurrence, character and extent of loss for which the claim is made.

Your Properly Filed Claim must be furnished to the Plan within 90 days after the end of the Benefit Period for which claim is made.

Failure to provide a Properly Filed Claim to the Plan within the time specified above will not reduce any Benefit if you show that the claim was given as soon as reasonably possible.

LIMITATION OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after expiration of the time within which a Properly Filed Claim is required by this Certificate.

PAYMENT OF BENEFITS

You authorize us to make payments directly to Providers giving Covered Services for which we provide Benefits under this Certificate. We also reserve the right to make payments directly to you .

You cannot assign your right to receive payment to anyone else, either before or after Covered Services are received .

Once a Provider gives a Covered Service, we will 'not honor a request not to pay the claims submitted.

Benefits under this Certificate will be based upon the Allowable Charge (as we determine) for Covered Services. A BlueTraditional Provider will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services . However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA

All Blue Cross and Blue Shield Plans participate in a national program called the "BlueCard Program". This national program benefits Blue Cross and Blue Shield Subscribers who receive Covered Services outside the state of Oklahoma.

When you obtain health care services through BlueCard outside the state of Oklahoma, the amount you pay for Covered Services is calculated on the ***lower*** of:

- The billed charges for your Covered Services; or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often this " negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, and other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an ***average*** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Subscriber liability calculation methods that differ from the usual Blue Cross method noted in the above paragraph or require a surcharge , Blue Cross and Blue Shield of Oklahoma would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of your Deductible and/or Coinsurance amounts whenever it is necessary so that we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Plan, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Contract and to determine its Benefits.

In determining whether services or supplies are Covered Services, the Plan will determine whether a service or supply is Medically Necessary under the Plan or if such service or supply is Experimental or Investigational. Blue Cross and Blue Shield of Oklahoma medical policies are used as guidelines for coverage determinations in health care benefit programs unless otherwise indicated. Medical technology is constantly evolving and these medical policies are subject to change. Copies of current medical policies may be obtained from the Plan upon request and may be found on the Plan's Web site at www.bcbsok.com.

Definitions

This section defines terms that have special meanings in this Certificate. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or it is a title.

ACTIVELY AT WORK

The active expenditure of time and energy in the services assigned by the Employer. You are considered Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day if you were Actively at Work on the work day before your Effective Date.

ALLOWABLE CHARGE

The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under the Contract. The Plan will use the following criteria to establish the Allowable Charge for ***Comprehensive Health Care Services:***

- **BlueTraditional Provider-** the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueTraditional Provider Agreement.
- **Out-of-NetworkProvider-** the Provider's usual charge, up to the amount that the Plan would reimburse a BlueTraditional Provider for the same service.

For Outpatient Prescription Drug Benefits, the Allowable Charge is determined as follows:

- **Participating Pharmacy-** the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy Agreement.
- **Out-of-NetworkPharmacy** - the Pharmacy's usual charge, up to the amount that the Plan would reimburse a Participating Pharmacy for the same service.

NOTE: For covered health care services received outside the state of Oklahoma, if the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the "Allowable Charge" will be determined by the on-site Blue Cross and Blue Shield Plan. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. In instances where the claim is not filed with the Host Plan the Allowable Charge for your out-of-network claims will be based upon the amount the Plan would have reimbursed a BlueTraditional Provider for the same service.

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or other Provider.

ANNUAL TRANSFER PERIOD

A period of 31 days immediately before the Contract Date Anniversary in which an Eligible Person who has coverage through the Employer's alternate Plan Group contract or BlueLincs HMO (if applicable) can apply to transfer coverage to this Certificate.

BENEFIT PERIOD

The period of time during which you receive Covered Services for which the Plan will provide Benefits.

BENEFITS

The payment, reimbursement and indemnification of any kind which you will receive from and through the Plan under this Certificate.

BLUECARD PROVIDER

The national network of participating Providers who have entered into an agreement with a Blue Cross and Blue Shield Plan to be a part of the BlueCard program.

BLUETRADITIONAL PROVIDER

A Provider who has entered into a BlueTraditional Provider Agreement with the Plan.

CALENDAR YEAR

The period of 12 months commencing on the first day of January and ending on the last day of the following December.

CERTIFICATE OF COVERAGE

A document providing information which is intended to enable an individual to establish his/her prior Creditable Coverage for the purposes of reducing any Preexisting Condition Exclusion imposed on the individual by any subsequent Group Health Plan coverage.

COBRA CONTINUATION COVERAGE

Coverage under the Group Contract for you and your Eligible Dependent with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Contract to Subscribers to whom a Qualifying Event has not occurred.

COINSURANCE

The percentage of Allowable Charges for Covered Services for which the Subscriber is responsible.

COMMUNITY HOME HEALTH CARE AGENCY

A Provider which provides nurses who visit the patient's home to give nursing and other needed care. This agency sees that each patient gets all care ordered by the Physician.

CONTRACT

The agreement (including the Group Application and any endorsements) between your Group and us, referred to as the Master Contract or Group Contract.

CONTRACT DATE

The date when coverage for your Group starts.

CONTRACT DATE ANNIVERSARY

The date the Group Contract will renew and each 12-consecutive-month renewal date thereafter.

COVERED SERVICE

A service or supply shown in this Certificate and given by a Provider for which we will provide Benefits.

CREDITABLE COVERAGE

Coverage of an individual from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid.

CUSTODIAL CARE

Aid to patients who need help with daily tasks like eating, dressing and walking. Custodial Care does not directly treat an injury or illness.

DEDUCTIBLE

A specified amount of Covered Services that you must incur before the Plan will start to pay its share of the remaining Covered Services.

DEPENDENT

A Subscriber other than the Member as shown in the ***Eligibility, Enrollment, Changes and Termination*** section.

DIAGNOSTIC SERVICE

A test or procedure performed when you have specific symptoms to detect or monitor your disease or condition. It must be ordered by a Physician.

- Radiology, ultrasound and nuclear medicine
- Laboratory and pathology
- ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing, as determined by the Plan

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

- It provides therapeutic benefits or enables the Subscriber to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;
- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

A person entitled to apply to be a Member as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

EMERGENCY CARE

Treatment for an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Subscriber's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

EMPLOYEE

An Eligible Person as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

EMPLOYER

A Group, as defined, in which there exists an employment relationship between a Member and the Group.

ENROLL

To become covered for Benefits under the Contract (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period (typically the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL

A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if **the Plan determines** that:

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or
- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

FAMILY COVERAGE

Coverage under this Certificate for the Member and one or more of the Member's Dependents.

FULL-TIME STUDENT

A person who is regularly attending an accredited secondary school, college or university as:

- An undergraduate student enrolled in 12 or more semester hours, or the academic equivalent; or
- A graduate student enrolled in nine or more semester hours, or the academic equivalent; or
- A graduate assistant student enrolled in six or more semester hours, or the academic equivalent.

GROUP

A classification of coverage whereby a corporation or other legal entity has agreed to establish a premium collection and payment system in order to provide an opportunity for its employees to acquire Plan coverage for health care expenses.

GROUP HEALTH PLAN

A plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An organized system of health care providing a comprehensive package of health services, through a group of Physicians, to a voluntarily enrolled membership, within a particular geographic area, on a fixed prepayment basis.

HOSPICE

A Provider which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families.

HOSPITAL

A Provider that is a short-term, acute care, general Hospital which:

- Is licensed;

- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service; and
- Is not, other than incidentally, a:
  - Skilled Nursing Facility;
  - Nursing home;
  - Custodial Care home;
  - Health resort;
  - Spa or sanitarium;
  - Place for rest;
  - Place for the aged;
  - Place for the treatment of Mental Illness;
  - Place for the treatment of alcoholism or drug abuse;
  - Place for the provision of Hospice care;
  - Place for the provision of rehabilitation care; or
  - Place for the treatment of pulmonary tuberculosis.

HOSPITAL ADMISSION

The period from your entry (admission) into a Hospital for Inpatient treatment until your discharge.

IDENTIFICATION CARD

The card issued to the Member by the Plan, bearing the Member's name, identification number, and Group number.

INCURRED

A charge is Incurred on the date you receive a service or supply for which the charge is made.

INDIVIDUAL CONVERSION

A classification of individual coverage other than Group for which the individual Member pays the premiums directly to the Plan or its depository.

INITIAL ENROLLMENT PERIOD

The 31-day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Contract.

INPATIENT

A Subscriber who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made.

LATE ENROLLEE

An Eligible Person or Eligible Dependent who Enrolls under the Contract at a time other than during:

- the Initial Enrollment Period; or

- a Special Enrollment Period for the individual.

However, an Eligible Person or Eligible Dependent is not considered a Late Enrollee if:

- the individual transfers from the Employer's alternate Plan Group Contract or BlueLincs HMO (if applicable) during the Annual Transfer Period; or
- a court has ordered coverage be provided for a spouse or minor or Dependent child under the Eligible Person's coverage and the request for enrollment is made within 31 days after issuance of the court order.

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

A licensed nurse with a degree from a school of practical or vocational nursing.

Low-DOSE MAMMOGRAPHY

The x-ray screening examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

MATERNITY SERVICES

Care required as a result of being pregnant, including prenatal care and postnatal care.

MEDICAL CARE

Professional services given by a Physician or other Provider to treat illness or injury.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

A service or supply given by a Hospital, Physician, or other Provider which the Plan determines is:

- Appropriate for symptoms and diagnosis to treat the condition, illness, disease or injury; and
- In line with standards of good medical practice; and
- Not primarily for your or your Provider's convenience; and
- The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your condition or the services you need require acute care as a bed patient and that you cannot receive safe or adequate care as an Outpatient.

MEDICARE

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

MEMBER

An Eligible Person who has enrolled for coverage.

MEMBER AND CHILDREN COVERAGE

Coverage under this Certificate for the Member and his or her Dependent child(ren).

MEMBER ONLY COVERAGE (OR SINGLE COVERAGE)

Coverage under this Certificate for the Member only.

MEMBER, SPOUSE AND CHILDREN COVERAGE (OR FAMILY COVERAGE)

Coverage under this Certificate for the Member, his or her spouse and Dependent child(ren).

MEMBER AND SPOUSE ONLY COVERAGE

Coverage under this Certificate for the Member and his or her spouse only.

MENTAL ILLNESS

An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, or emotional disturbances are the dominating feature, regardless of whether such disorder is caused by mental, physical, organic, or chemical deficiency.

OPEN ENROLLMENT PERIOD

A period of 31 days immediately before the Group's Contract Date Anniversary (renewal date) during which an individual who previously declined coverage may Enroll for coverage under the Contract as a Late Enrollee.

ORTHOGNATHIC SURGERY

Services or supplies received for correction of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

OUT-OF-NETWORK PHARMACY

A Pharmacy that has not entered into a Participating Pharmacy Agreement with the Plan.

OUT-OF-NETWORK PROVIDER

A Provider that has not entered into an agreement with the Plan to be a part of its BlueTraditional or BlueCard Provider networks.

OUTPATIENT

A Subscriber who receives services or supplies while not an Inpatient.

PARTICIPATING PHARMACY

A Pharmacy that has entered into a Participating Pharmacy Agreement with the Plan.

PHARMACY

A person, firm or corporation duly authorized by state law to dispense Prescription Drugs.

PHYSICIAN

A person who is a professional practitioner of a Healing Art defined and recognized by law, and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or Surgery or other procedures and provide services within the scope of such license.

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

PLAN

Blue Cross and Blue Shield of Oklahoma.

PRECERTIFICATION

Certification from the Plan before the services are rendered that, based upon the information presented by the Subscriber or his/her Provider at the time Precertification is requested, the proposed treatment meets the Plan's guidelines for Medical Necessity.

Precertification does not guarantee that the care and services a Subscriber receives are eligible for Benefits under the Contract. At the time the Subscriber's claims are submitted, they will be reviewed in accordance with the terms of the Contract.

PREEXISTING CONDITION

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A Preexisting Condition does not include pregnancy, nor can it be applied to a newborn or adopted child under age 18, as long as the child became covered under the Certificate within 31 days of birth or adoption.

PREEXISTING CONDITION EXCLUSION

A 12-month or 18-month period during which no Benefits will be provided for a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the Enrollment Date.

PRESCRIPTION DRUG

A medicinal substance required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal Law prohibits dispensing without a prescription."

PROPERLY FILED CLAIM

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider's itemized statement of services rendered and related charges; and medical records, when requested by the Plan.

PROVIDER

A Hospital, Physician, or other practitioner or Provider of medical services or supplies licensed to render Covered Services and performing within the scope of such license.

QUALIFYING EVENT

Any one of the following events which, but for the COBRA Continuation Coverage provisions of this Certificate, would result in the loss of a Subscriber's coverage:

- The death of the covered Employee;
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;
- A Dependent child ceasing to be eligible as defined under the Contract.

REGISTERED NURSE (RN)

A licensed nurse with a degree from a school of nursing.

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Subscriber.

SIGNIFICANT BREAK IN COVERAGE

A period of 63 consecutive days during all of which the individual did not have any Creditable Coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break In Coverage.

SKILLED NURSING FACILITY

A Provider which mainly provides Inpatient skilled nursing and related services to patients who need skilled nursing services around the clock but who do not need acute care in a Hospital bed. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Custodial Care, ambulatory, or part-time care; or
- Treatment for Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

SPECIAL ENROLLMENT PERIOD

A period during which an individual who previously declined coverage is allowed to Enroll under the Contract without having to wait until the Group's next regular Open Enrollment Period.

STOP-LOSS LIMIT

A specified dollar amount of Covered Services which are reimbursed at less than 100% of the Allowable Charge to or on behalf of a Subscriber during a Benefit Period. When the Stop-Loss Limit is reached, the level of Benefits is increased as specified in the *Schedule of Benefits.*

SUBSCRIBER

The Member and each of his or her Dependents (if any) covered under this Certificate.

SURGERY

- The performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Usual and related preoperative and postoperative care.

THERAPY SERVICE

The following services and supplies ordered by a Physician when used to treat and promote your recovery from an illness or injury:

- **Radiation Therapy** - the treatment of disease by x-ray, radium, or radioactive isotopes.
- **Chemotherapy** - the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High-Dose Chemotherapy. High-Dose Chemotherapy is specifically addressed in certain sections under ***"Human Organ, Tissue and Bone Marrow Transplant Services."***
- **Respiratory Therapy** - introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** - the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- **Physical Therapy** - the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- **Occupational Therapy** - treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Speech Therapy** - treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

TOTAL DISABILITY (OR TOTALLY DISABLED)

A condition resulting from disease or injury in which, as certified by a Physician:

- The Subscriber is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Subscriber is not in fact engaged in any occupation for wages or profit; or
- If the Subscriber does not usually work for wages or profit, the Subscriber cannot do the normal activities of a person of the same age and sex.

The Plan reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan will make the final determination as to whether the Subscriber is Totally Disabled.

WAITING PERIOD

The period that must pass before an Eligible Person or Dependent is eligible to Enroll under the terms of a Group Health Plan. If an Eligible Person or Dependent Enrolls as a Late Enrollee or during a Special Enrollment Period, any period before such late or special enrollment is not a Waiting Period.

Your Health Care Benefit Program

BluePreferred Certificate of Benefits

BlueCross BlueShield of Oklahoma
Experience. Wellness. Everywhere.™

1215 South Boulder | P.O. Box 3283 | Tulsa, Oklahoma | 74102–3283

70260.0208

EXHIBIT
2

BluePreferred
Certificate Insert

Your Benefits under this program are subject to the following provisions:

OFFICE VISIT COPAYMENT	$20 for each visit to a BluePreferred PPO or BlueCard PPO Physician's office.
DEDUCTIBLE	
Out-of-Network Hospital Deductible	$300 per Inpatient Hospital Admission.
Emergency Room Deductible	$100 for each visit to a Hospital emergency room.
Benefit Period Deductible	
BluePreferred PPO and BlueCard PPO Provider Services	$500 per Benefit Period per Subscriber.
Out-of-Network Provider Services	$800 per Benefit Period per Subscriber.
STOP-LOSS LIMIT	
BluePreferred PPO and BlueCard PPO Provider Services	$5,000 per Benefit Period per Subscriber.
Out-of-Network Provider Services	$10,000 per Benefit Period per Subscriber.

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

Table of Contents

Certificate

This Certificate is issued according to the terms of your Group Health Plan. It contains the principal provisions of the Group Contract and its ***Schedule of Benefits.*** In the event of conflict between the Contract and this Certificate, the terms of the Contract will prevail.

If a word or phrase starts with a capital letter, it has a special meaning in this Certificate. It is defined in the ***Definitions*** section, where used in the text, or it is a title.

Your Group has contracted with **Blue Cross and Blue Shield of Oklahoma** (called the Plan, we, us, or our) to provide the Benefits described in this Certificate. Blue Cross and Blue Shield of Oklahoma having issued a Group Contract to the Group, certifies that all persons who have:

- applied for coverage under the Contract;
- paid for the coverage;
- satisfied the conditions specified in the ***Eligibility, Enrollment, Changes and Termination*** section; and
- been approved by the Plan;

are covered by the Group Contract. Covered persons are called Subscribers (or you, your).

Beginning on your Effective Date, we agree to provide you the Benefits described in this Certificate.

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Important Information

PLEASE READ THIS SECTION CAREFULLY! It explains the role the Blue Cross and Blue Shield of Oklahoma Provider networks play in your health care coverage. It also explains important cost containment features in your health care program. Together, these features allow you to receive quality health care in cost-effective settings, while helping you experience lower out-of-pocket expenses.

By becoming familiar with these programs, you will be assured of receiving the maximum Benefits possible whenever you need to use your health care services.

THE BLUEPREFERRED PROVIDER NETWORK

BluePreferred is a Preferred Provider Organization (PPO) plan that offers a wide choice of network Providers. Blue Cross and Blue Shield of Oklahoma has negotiated special agreements with Hospitals, Outpatient facilities, Physicians and other health care professionals from many specialties. These participating health care Providers work with Blue Cross and Blue Shield of Oklahoma to help keep down the cost of health care. Although you are free to choose any health care Provider for your services, your BluePreferred coverage will provide the highest level of Benefits if you use a BluePreferred Provider.

BluePreferred Providers are not employees, agents or other legal representatives of Blue Cross and Blue Shield of Oklahoma.

HOW YOUR BLUEPREFERRED COVERAGE WORKS

Your BluePreferred coverage is designed to give Subscribers some control over the cost of their own health care. Subscribers continue to have complete freedom of choice in their Provider selection. However, the program offers considerable financial advantages to Subscribers who choose to use a BluePreferred Provider.

IMPORTANT: Keep in mind that all Covered Services (including ancillary services such as x-ray and laboratory services, anesthesia, etc.) must be performed by a BluePreferred Provider in order to receive the highest level of Benefits under this Certificate. If your Physician prescribes these services, request that he/she refer you to a BluePreferred Provider whenever possible.

COST SHARING FEATURES OF YOUR COVERAGE

As a participant in this Group Health Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable Copayment, Deductible and Coinsurance provisions of your coverage, as well as any charges for which Benefits are not provided. You may also be responsible for a portion of your health care premiums, depending upon the terms of your Group Health Plan. Check with your Group Administrator for specific premium amounts applicable to the coverage you have selected for you and your family.

SELECTING A PROVIDER

There are several ways to find out whether or not a Hospital, Physician, or other Provider is a network Provider.

Upon enrollment, you will receive a directory of network Providers at no charge to you. Providers are listed alphabetically and by specialty. The directory also indicates the Hospitals where each Physician practices. A listing of Oklahoma network Providers is also available on-line through the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com.

Although every effort is made to provide an accurate listing of network Providers, additions and deletions will occur. Therefore, you should check with Blue Cross and Blue Shield of Oklahoma or the Provider to be sure of the Provider's network status.

When you call Blue Cross and Blue Shield of Oklahoma, ask our Customer Service Representative whether or not the Provider is a network Provider. Simply call our toll-free number at 1-800-942-5837.

Of course, you may ask the Provider directly if they are a network Provider. **Be sure they understand you are inquiring about the Blue Cross and Blue Shield of Oklahoma BluePreferred Provider network.**

THE BLUECARD PPO PROGRAM

As a Blue Cross and Blue Shield Plan Member, you enjoy the convenience of carrying your Identification Card — The BlueCard. The BlueCard Program allows you to use a Blue Cross and Blue Shield PPO Physician or Hospital outside the state of Oklahoma and to receive the advantages of PPO benefits and savings.

- **Finding a PPO Physician or Hospital**

  When you're outside of Oklahoma and you need to find information about a Blue Cross and Blue Shield PPO Physician or Hospital, just call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583), or you may refer to the BlueCard Doctor and Hospital Finder at http://www.bluecares.com. We'll help you locate the nearest PPO Physician or Hospital. *Remember, you are responsible for receiving Precertification from Blue Cross and Blue Shield of Oklahoma.* As always, in case of an emergency, you should seek immediate care from the closest health care Provider.

- **Available Care Coast to Coast**

  Show your Identification Card to any Blue Cross and Blue Shield PPO Physician or Hospital across the USA. The PPO Physicians and Hospitals can verify your membership eligibility and coverage with Blue Cross and Blue Shield of Oklahoma. When you visit a PPO Physician or Hospital, you should have no claim forms to file and no billing hassles.

- **Remember to Always Carry the BlueCard**

  Make sure you always carry your Identification Card — The BlueCard. And be sure to use Blue Cross and Blue Shield PPO Physicians and Hospitals whenever you're outside the state of Oklahoma and need health care.

Some local variations in Benefits do apply. If you need more information, call Blue Cross and Blue Shield of Oklahoma today.

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of your Copayment, Deductible and/or Coinsurance amounts whenever it is necessary so that we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BluePreferred & BlueCard PPO Provider Services	Out-of-Network Provider Services
HOSPITAL SERVICES	80%	60%
SURGICAL/MEDICAL SERVICES		
Physician's Office Visits		
Preventive Care Services (Limited to $300 per Benefit Period for Subscribers age 19 or older)	100%	100%
Annual Routine Gynecological/Obstetrical Examination and Pap Smear	100%	100%
Covered Childhood Immunizations (Limited to Subscribers under age 19)	100%	100%
Other Physicians' Office Visits	100%*	60%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES		
Routine Low-Dose Mammography (Limited to $115 per screening)	100%	100%
All Other Covered Diagnostic Services	80%	60%
OUTPATIENT THERAPY SERVICES	80%	60%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%
PSYCHIATRIC CARE SERVICES		
Covered Services for Treatment of Severe Mental Illness	80%	60%
All Other Covered Psychiatric Care Services	50%	50%
AMBULANCE SERVICES	100%	100%
PRIVATE DUTY NURSING SERVICES	80%	60%
REHABILITATION CARE	80%	60%
SKILLED NURSING FACILITY SERVICES	80%	60%

** Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 80% of Allowable Charges after satisfaction of the Deductible.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BluePreferred & BlueCard PPO Provider Services	Out-of-Network Provider Services
HOME HEALTH CARE SERVICES	80%	60%
HOSPICE SERVICES	80%	60%
OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES	80%*	60%
ALL OTHER COVERED SERVICES	80%	60%

**Applies to prescriptions filled at a Participating Pharmacy, regardless of prescribing Physician's status as a BluePreferred, BlueCard PPO or Out-of-Network Provider.*

Comprehensive Health Care Services

This section lists the Covered Services under your health care program. **Please note that services must be Medically Necessary in order to be covered under this program.**

HOSPITAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Hospital or other Provider.

- **Bed and Board**

  Bed, board and general nursing service in:

  — A room with two or more beds;

  — A private room (private room allowance is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;

  — A bed in a Special Care Unit which gives intensive care to the critically ill.

  Inpatient services are subject to the Precertification guidelines of this Certificate (see *"Important Information"*). If you fail to comply with these guidelines, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by $500, provided the Plan determines that Benefits are payable upon receipt of a claim.

- **Ancillary Services**

  — Operating, delivery and treatment rooms;

  — Prescribed drugs;

  — Whole blood, blood processing and administration;

  — Anesthesia supplies and services rendered by an employee of the Hospital or other Provider;

  — Medical and surgical dressings, supplies, casts and splints;

  — Oxygen;

  — Subdermally implanted devices or appliances necessary for the improvement of physiological function;

  — Diagnostic Services;

  — Therapy Services.

  Benefits for Speech Therapy are limited to Inpatient services only.

- **Emergency Accident Care**

  Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.

- **Emergency Medical Care**

  Outpatient emergency Hospital services and supplies to treat a sudden and acute medical condition that requires prompt Medical Care.

- **Surgery**

  Hospital services and supplies for Outpatient Surgery furnished by an employee of the Hospital or other Provider other than the surgeon or assistant surgeon.

- **Routine Nursery Care**

  — Inpatient Hospital Services for Routine Nursery Care of a newborn Subscriber.

  — Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Certificate:

    ° the infant will be considered as a Subscriber in its own right and will be entitled to the same Benefits as any other Subscriber under this Certificate; and

    ° a separate Deductible will apply to the newborn's Hospital confinement.

  Benefits are not provided for Routine Nursery Care for an infant born to a Dependent child.

SURGICAL/MEDICAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Physician or other Provider.

- **Surgery**

  Payment includes visits before and after Surgery.

  — If an incidental procedure* is carried out at the same time as a more complex primary procedure, then Benefits will be payable for only the primary procedure. **Separate Benefits will not be payable for any incidental procedures performed at the same time.**

  — When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:

    ° the primary procedure; plus

    ° 50% of the amount payable for each of the additional procedures had those procedures been performed alone.

  — Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

  Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant surgeon only if determined Medically Necessary by the Plan.

- **Anesthesia**

  Administration of anesthesia by a Physician or other Provider who is not the surgeon or the assistant surgeon.

**A procedure carried out at the same time as a primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and, therefore, should not be reimbursed separately.*

- **Inpatient Medical Services**

  Medical Care when you are an Inpatient for a condition not related to Surgery, pregnancy, or Mental Illness, except as specified.

  — Inpatient Medical Care Visits

  Inpatient Medical Care visits are limited to one visit or other service per day by the attending Physician.

  — Intensive Medical Care

  Constant Physician attendance and treatment when your condition requires it for a prolonged time.

  — Concurrent Care

  - Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.
  - If the nature of the illness or injury requires, care by two or more Physicians during one Hospital stay.

  — Consultation

  Consultation by another Physician when requested by your attending Physician, **limited to one visit or other service per day for each consulting Physician.** Staff consultations required by Hospital rules are excluded.

  — Newborn Well Baby Care

  Routine Nursery Care visits to examine a newborn Subscriber, limited to the first 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section. No additional Inpatient visits are covered for well baby care.

- **Outpatient Medical Services**

  Outpatient Medical Care that is not related to Surgery, pregnancy, or Mental Illness, except as specified.

  — Emergency Accident Care

  Treatment of accidental bodily injuries.

  — Emergency Medical Care

  Treatment of a sudden and acute medical condition that requires prompt Medical Care.

  — Home, Office, and Other Outpatient Visits

  Visits and consultation for the examination, diagnosis, and treatment of an injury or illness.

  — Preventive Care Services

  Services performed by a Provider as "routine" or "screening" services, **limited to $300 per Benefit Period for Subscribers age 19 or older.** Routine or screening examinations which meet the guidelines for mandated Benefits, established by Oklahoma state law, shall not be included as Preventive Care Services, but shall be subject to the limitations specified elsewhere in this Certificate.

  Unless specifically provided by Oklahoma state law, the following services are not included:

  - Hearing or vision screening examinations;
  - Medical supplies or equipment;
  - Routine foot care.

— Routine Gynecological/Obstetrical Examination and Pap Smear

Routine gynecological/obstetrical examination and Pap smear performed in the Physician's office, limited to once each Benefit Period.

— Contraceptive Devices

Contraceptive devices which are:

- placed or prescribed by a Physician;
- intended primarily for the purpose of preventing human conception; and
- approved by the U. S. Food and Drug Administration as acceptable methods of contraception.

— Prostate Cancer Screening

Annual screening for the early detection of prostate cancer in male Subscribers, including a prostate-specific antigen blood test and a digital rectal examination. Benefits are limited to one screening exam per Benefit Period and shall not exceed $65 per screening.

— Colorectal Cancer Screening

Colorectal cancer examinations and laboratory tests for cancer screening for any nonsymptomatic Subscriber, in accordance with standard, accepted published medical practice guidelines.

— Immunizations, limited to:

- Diphtheria, tetanus, and pertussis (whooping cough) vaccine (DTaP);
- Tetanus vaccine;
- Poliomyelitis vaccine;
- Measles virus vaccine;
- Mumps virus vaccine;
- German measles (rubella) vaccine;
- Measles, mumps, and rubella vaccine (MMR);
- Varicella (chicken pox) vaccine;
- Pneumonia vaccine;
- Pneumococcal vaccine;
- Haemophilus influenzae type b (Hib);
- Rotavirus vaccine, limited to Subscribers under age 19;
- Human papillovirus vaccine (HPV), limited to Subscribers under age 19;
- Hepatitis A and hepatitis B vaccine, limited to Subscribers under age 19;
- Meningococcal vaccine, limited to Subscribers under age 19;
- Any other immunization required for children by the Oklahoma State Board of Health.

— Child Health Supervision Services

The periodic review of a child's physical and emotional status by a Physician or other Provider pursuant to a Physician's supervision, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

Child Health Supervision Services must be rendered during a periodic review, provided by or under the supervision of a single Physician during the course of one visit.

Child Health Supervision Services are limited to Subscribers under age 19.

— Audiological Services

Audiological services and hearing aids, limited to:

- **One hearing aid per ear every 48 months for Subscribers up to age 18; and**
- **Up to four additional ear molds per Benefit Period for Subscribers up to two years of age.**

Hearing aids must be prescribed, filled and dispensed by a licensed audiologist.

— Bone Density Testing

Bone density testing when ordered or performed by a Physician or other Provider. **Benefits are limited to $150 for each bone density test.**

Outpatient Diagnostic Services

- Radiology, Ultrasound and Nuclear Medicine

Radiological services include bilateral mammography screening (two view film study of each breast) for the presence of occult breast cancer, limited to:

— one screening examination every five years for female Subscribers age 35 through 39; and

— one *annual* screening examination for female Subscribers age 40 or older.

Benefits for *routine* Low-Dose Mammography shall be limited to $115 per screening.

- Laboratory and Pathology
- ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Plan

Outpatient Therapy Services

- Radiation Therapy
- Chemotherapy
- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy and Occupational Therapy

Benefits for Outpatient Physical Therapy and Outpatient Occupational Therapy are limited to a combined maximum of 25 visits per Benefit Period per Subscriber.

Exclusions

This section lists what is not covered. We want to be sure that you do not expect Benefits that are not included in this Certificate. It also explains the Preexisting Condition provisions in your coverage.

What Is Not Covered

Except as otherwise specifically stated in this Certificate, we do not provide Benefits for services, supplies or charges:

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which we determine are not Medically Necessary, except as specified.
- Received from other than a Provider.
- Which are in excess of the Allowable Charge, as determined by the Plan.
- Which the Plan determines are Experimental/Investigational in nature.
- For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer–employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - — You agree to:
    - ° pursue your rights under the workers' compensation laws;
    - ° take no action prejudicing the rights and interests of the Plan; and
    - ° cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - — If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - ° hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - ° repay the Plan any money recovered from your employer or insurance carrier.
- To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- For any illness or injury suffered after the Subscriber's Effective Date as a result of war or act of war, declared or undeclared, when serving in the military or an auxiliary unit thereto.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:

  — needed to repair conditions resulting from an accidental injury; or

  — for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.

- Received from a member of your immediate family.
- Received before your Effective Date.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- Received after your coverage stops.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations, except as specified in the ***Comprehensive Health Care Services*** section.
- For reverse sterilization.
- For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:

  — the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or

  — for the improvement of the physiological functioning of a malformed body member.

  Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures.

- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:

— severely disabled; or

— eight years of age or under;

and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers up to age 18. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury.
- For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- For Prescription Drugs prescribed and used for cosmetic purposes.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:

  — Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under; or

  — Prescription Drug therapy (provided this Certificate includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD in Subscribers age 19 and under.

- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan–approved Provider.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under ***"Human Organ, Tissue and Bone Marrow Transplant Services"***.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high– or low–dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, licensed clinical social worker or person with a master's degree in social work.
- For services rendered by licensed professional counselors, marital and family therapists or counselors or licensed drug and alcohol counselors.
- For services rendered by midwives.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Certificate.

We may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for Benefits under this Certificate. You must provide to us all documents needed to enforce our rights under this provision.

PREEXISTING CONDITION EXCLUSION

Your Benefits under this Certificate are subject to a Preexisting Condition Exclusion period. However, the Preexisting Condition Exclusion will only apply to you and/or a Dependent if the following conditions are met:

- **Six-month Look-back Rule**

  — The Preexisting Condition Exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the Subscriber's Enrollment Date.

  — In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.

  — The six-month look-back period is based on the six-month "anniversary date" of the Enrollment Date.

- **Length of Preexisting Condition Exclusion Period**

  The exclusion period cannot extend for more than 12 months (18 months for Late Enrollees*) after the Enrollment Date. The 12-month or 18-month "look forward" period is also based on the anniversary date of the Enrollment Date.

- **Reduction of Preexisting Condition Exclusion Period by Prior Coverage**

  In general, the Preexisting Condition Exclusion period must be reduced by the individual's days of "Creditable Coverage" as of the Enrollment Date. Creditable Coverage includes coverage from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid. However, days of Creditable Coverage that occur before a Significant Break In Coverage (63 or more consecutive days) will not be counted in reducing the Preexisting Condition Exclusion period.

  In addition, the Preexisting Condition Exclusion period will be *waived* for an individual with prior Creditable Coverage through a Health Maintenance Organization, and who Enrolls under this Certificate without a Significant Break In Coverage.

- **Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children**

  A Preexisting Condition Exclusion cannot apply to pregnancy. In addition, a Preexisting Condition Exclusion period will not be applied to a newborn, an adopted child under age 18, or a child Placed for Adoption under age 18, if the child becomes covered within 31 days of birth, adoption, or Placement for Adoption.

- **Notice to Subscribers**

  The Plan may only impose a Preexisting Condition Exclusion with respect to a Subscriber by notifying the Subscriber, in writing, of the existence and terms of any Preexisting Condition Exclusion under the Plan and of the rights of the Subscriber to demonstrate Creditable Coverage. The Plan will assist the Subscriber in obtaining a Certificate of Coverage from any prior health plan or issuer, if necessary.

The Plan may, without waiving the above provisions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the above Preexisting Condition limitations. If it is later determined that the care and services are excluded from the Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Certificate. The Subscriber must provide the Plan with all documents it needs to enforce its rights under this provision.

* *See the Definitions section for an explanation of this term.*

General Provisions

This section tells:

- The Benefits to which you are entitled;
- How to get Benefits;
- Your relationship with Hospitals, Physicians, and other Providers;
- Your relationship with us;
- Coordination of Benefits when you have other coverage.

Benefits to Which You Are Entitled

We provide only the Benefits specified in this Certificate.

Only Subscribers are entitled to Benefits from us and they may not transfer their rights to Benefits to anyone else.

Benefits for Covered Services specified in this Certificate will be covered only for those Providers specified in this Certificate.

Prior Approval

The Plan does not give prior approval or guarantee Benefits for any services through its Precertification process, or in any oral or written communication to Subscribers or other persons or entities requesting such information or approval.

Notice and Properly Filed Claim

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to you. Upon receipt of written notice, the Plan will furnish claim forms to you for submitting a Properly Filed Claim. If the forms are not furnished within 15 days after the Plan receives your notice, you can comply with the Properly Filed Claim requirements by forwarding to the Plan, within the time period set forth below, written proof covering the occurrence, character and extent of loss for which the claim is made.

Your Properly Filed Claim must be furnished to the Plan within 90 days after the end of the Benefit Period for which claim is made.

Failure to provide a Properly Filed Claim to the Plan within the time specified above will not reduce any Benefit if you show that the claim was given as soon as reasonably possible.

Limitation of Actions

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after expiration of the time within which a Properly Filed Claim is required by this Certificate.

PAYMENT OF BENEFITS

You authorize us to make payments directly to Providers giving Covered Services for which we provide Benefits under this Certificate. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, either before or after Covered Services are received.

Once a Provider gives a Covered Service, we will not honor a request not to pay the claims submitted.

Benefits under this Certificate will be based upon the Allowable Charge (as we determine) for Covered Services. A BluePreferred Provider will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

In some cases, Covered Services may be rendered by a Provider who has a Participating Provider Agreement (*other than a BluePreferred Provider Agreement)* with the Plan. These Providers (called BlueTraditional Providers) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. Subscribers who use BlueTraditional Providers are responsible for amounts over the "Allowable Charge," *up to but not exceeding* the "Maximum Reimbursement Allowance" specified in the Provider's Participating Provider Agreement.

BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA

All Blue Cross and Blue Shield Plans participate in a national program called the "BlueCard Program". This national program benefits Blue Cross and Blue Shield Subscribers who receive Covered Services outside the state of Oklahoma.

When you obtain health care services through BlueCard outside the state of Oklahoma, the amount you pay for Covered Services is calculated on the *lower* of:

- The billed charges for your Covered Services; or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, and other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an *average* expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Subscriber liability calculation methods that differ from the usual Blue Cross method noted in the above paragraph or require a surcharge, Blue Cross and Blue Shield of Oklahoma would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of your Copayment, Deductible and/or Coinsurance amounts whenever it is necessary so that we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

Definitions

This section defines terms that have special meanings in this Certificate. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or it is a title.

Actively at Work

The active expenditure of time and energy in the services assigned by the Employer. You are considered Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day if you were Actively at Work on the work day before your Effective Date.

Allowable Charge

The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under the Contract. The Plan will use the following criteria to establish the Allowable Charge for ***Comprehensive Health Care Services***:

- **BluePreferred Provider** — the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BluePreferred Provider Agreement.
- **Out-of-Network Provider** — the Provider's usual charge, up to the amount that the Plan would reimburse a BluePreferred Provider for the same service.

For Outpatient Prescription Drug Benefits, the Allowable Charge is determined as follows:

- **Participating Pharmacy** — the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy Agreement.
- **Out-of-Network Pharmacy** — the Pharmacy's usual charge, up to the amount that the Plan would reimburse a Participating Pharmacy for the same service.

NOTE: For covered health care services received outside the state of Oklahoma, if the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the "Allowable Charge" will be determined by the on-site Blue Cross and Blue Shield Plan. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. In instances where the claim is not filed with the Host Plan the Allowable Charge for your out-of-network claims will be based upon the amount the Plan would have reimbursed a BluePreferred Provider for the same service.

Ambulatory Surgical Facility

A Provider with an organized staff of Physicians which:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or other Provider.

Annual Transfer Period

A period of 31 days immediately before the Contract Date Anniversary in which an Eligible Person who has coverage through the Employer's alternate Plan Group contract or BlueLines HMO (if applicable) can apply to transfer coverage to this Certificate.

BENEFIT PERIOD

The period of time during which you receive Covered Services for which the Plan will provide Benefits.

BENEFITS

The payment, reimbursement and indemnification of any kind which you will receive from and through the Plan under this Certificate.

BLUECARD PPO PROVIDER

The national network of participating PPO Providers who have entered into an agreement with a Blue Cross and Blue Shield Plan to be a part of the BlueCard PPO program.

BLUEPREFERRED PROVIDER

A Provider who has entered into a BluePreferred Provider Agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's allowance as payment for such Covered Services.

CALENDAR YEAR

The period of 12 months commencing on the first day of January and ending on the last day of the following December.

CERTIFICATE OF COVERAGE

A document providing information which is intended to enable an individual to establish his/her prior Creditable Coverage for the purposes of reducing any Preexisting Condition Exclusion imposed on the individual by any subsequent Group Health Plan coverage.

COBRA CONTINUATION COVERAGE

Coverage under the Group Contract for you and your Eligible Dependent with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Contract to Subscribers to whom a Qualifying Event has not occurred.

COINSURANCE

The percentage of Allowable Charges for Covered Services for which the Subscriber is responsible.

COMMUNITY HOME HEALTH CARE AGENCY

A Provider which provides nurses who visit the patient's home to give nursing and other needed care. This agency sees that each patient gets all care ordered by the Physician.

CONTRACT

The agreement (including the Group Application and any endorsements) between your Group and us, referred to as the Master Contract or Group Contract.

CONTRACT DATE

The date when coverage for your Group starts.

CONTRACT DATE ANNIVERSARY

The date the Group Contract will renew and each 12-consecutive-month renewal date thereafter.

COPAYMENT

A fixed dollar amount required to be paid by or on behalf of a Subscriber in connection with the delivery of Covered Services in a BluePreferred Physician's office.

COVERED SERVICE

A service or supply shown in this Certificate and given by a Provider for which we will provide Benefits.

CREDITABLE COVERAGE

Coverage of an individual from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid.

CUSTODIAL CARE

Aid to patients who need help with daily tasks like eating, dressing and walking. Custodial Care does not directly treat an injury or illness.

DEDUCTIBLE

A specified amount of Covered Services that you must incur before the Plan will start to pay its share of the remaining Covered Services.

DEPENDENT

A Subscriber other than the Member as shown in the ***Eligibility, Enrollment, Changes and Termination*** section.

DIAGNOSTIC SERVICE

A test or procedure performed when you have specific symptoms to detect or monitor your disease or condition. It must be ordered by a Physician.

- Radiology, ultrasound and nuclear medicine
- Laboratory and pathology
- ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing, as determined by the Plan

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

- It provides therapeutic benefits or enables the Subscriber to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;
- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

A person entitled to apply to be a Member as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

EMERGENCY CARE

Treatment for an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Subscriber's health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

EMPLOYEE

An Eligible Person as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

EMPLOYER

A Group, as defined, in which there exists an employment relationship between a Member and the Group.

ENROLL

To become covered for Benefits under the Contract (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period (typically the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL

A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if the Plan determines that:

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or
- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

FAMILY COVERAGE

Coverage under this Certificate for the Member and one or more of the Member's Dependents.

FULL-TIME STUDENT

A person who is regularly attending an accredited secondary school, college or university as:

- An undergraduate student enrolled in 12 or more semester hours, or the academic equivalent; or
- A graduate student enrolled in nine or more semester hours, or the academic equivalent; or
- A graduate assistant student enrolled in six or more semester hours, or the academic equivalent.

GROUP

A classification of coverage whereby a corporation or other legal entity has agreed to establish a premium collection and payment system in order to provide an opportunity for its employees to acquire Plan coverage for health care expenses.

GROUP HEALTH PLAN

A plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An organized system of health care providing a comprehensive package of health services, through a group of Physicians, to a voluntarily enrolled membership, within a particular geographic area, on a fixed prepayment basis.

HOSPICE

A Provider which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families.

HOSPITAL

A Provider that is a short–term, acute care, general Hospital which:

- Is licensed;
- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24–hour nursing service; and
- Is not, other than incidentally, a:
  - — Skilled Nursing Facility;
  - — Nursing home;
  - — Custodial Care home;
  - — Health resort;
  - — Spa or sanitarium;
  - — Place for rest;
  - — Place for the aged;
  - — Place for the treatment of Mental Illness;
  - — Place for the treatment of alcoholism or drug abuse;
  - — Place for the provision of Hospice care;
  - — Place for the provision of rehabilitation care; or
  - — Place for the treatment of pulmonary tuberculosis.

HOSPITAL ADMISSION

The period from your entry (admission) into a Hospital for Inpatient treatment until your discharge.

IDENTIFICATION CARD

The card issued to the Member by the Plan, bearing the Member's name, identification number, and Group number.

INCURRED

A charge is Incurred on the date you receive a service or supply for which the charge is made.

INDIVIDUAL CONVERSION

A classification of individual coverage other than Group for which the individual Member pays the premiums directly to the Plan or its depository.

INITIAL ENROLLMENT PERIOD

The 31–day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Contract.

INPATIENT

A Subscriber who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made.

LATE ENROLLEE

An Eligible Person or Eligible Dependent who Enrolls under the Contract at a time other than during:

- the Initial Enrollment Period; or
- a Special Enrollment Period for the individual.

However, an Eligible Person or Eligible Dependent is not considered a Late Enrollee if:

- the individual transfers from the Employer's alternate Plan Group Contract or BlueLincs HMO (if applicable) during the Annual Transfer Period; or
- a court has ordered coverage be provided for a spouse or minor or Dependent child under the Eligible Person's coverage and the request for enrollment is made within 31 days after issuance of the court order.

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

A licensed nurse with a degree from a school of practical or vocational nursing.

LOW-DOSE MAMMOGRAPHY

The x-ray screening examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

MATERNITY SERVICES

Care required as a result of being pregnant, including prenatal care and postnatal care.

MEDICAL CARE

Professional services given by a Physician or other Provider to treat illness or injury.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

A service or supply given by a Hospital, Physician, or other Provider which the Plan determines is:

- Appropriate for symptoms and diagnosis to treat the condition, illness, disease or injury; and
- In line with standards of good medical practice; and
- Not primarily for your or your Provider's convenience; and
- The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your condition or the services you need require acute care as a bed patient and that you cannot receive safe or adequate care as an Outpatient.

MEDICARE

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

MEMBER

An Eligible Person who has enrolled for coverage.

MEMBER AND CHILDREN COVERAGE

Coverage under this Certificate for the Member and his or her Dependent child(ren).

MEMBER ONLY COVERAGE (OR SINGLE COVERAGE)

Coverage under this Certificate for the Member only.

MEMBER, SPOUSE AND CHILDREN COVERAGE (OR FAMILY COVERAGE)

Coverage under this Certificate for the Member, his or her spouse and Dependent child(ren).

MEMBER AND SPOUSE ONLY COVERAGE

Coverage under this Certificate for the Member and his or her spouse only.

MENTAL ILLNESS

An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, or emotional disturbances are the dominating feature, regardless of whether such disorder is caused by mental, physical, organic, or chemical deficiency.

OPEN ENROLLMENT PERIOD

A period of 31 days immediately before the Group's Contract Date Anniversary (renewal date) during which an individual who previously declined coverage may Enroll for coverage under the Contract as a Late Enrollee.

ORTHOGNATHIC SURGERY

Services or supplies received for correction of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

OUT-OF-NETWORK PHARMACY

A Pharmacy that has not entered into a Participating Pharmacy Agreement with the Plan.

OUT-OF-NETWORK PROVIDER

A Provider that has not entered into an agreement with the Plan to be a part of its BluePreferred or BlueCard PPO Provider networks.

OUTPATIENT

A Subscriber who receives services or supplies while not an Inpatient.

PARTICIPATING PHARMACY

A Pharmacy that has entered into a Participating Pharmacy Agreement with the Plan.

PHARMACY

A person, firm or corporation duly authorized by state law to dispense Prescription Drugs.

PHYSICIAN

A person who is a professional practitioner of a Healing Art defined and recognized by law, and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or Surgery or other procedures and provide services within the scope of such license.

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

PLAN

Blue Cross and Blue Shield of Oklahoma.

PRECERTIFICATION

Certification from the Plan before the services are rendered that, based upon the information presented by the Subscriber or his/her Provider at the time Precertification is requested, the proposed treatment meets the Plan's guidelines for Medical Necessity.

Precertification does not guarantee that the care and services a Subscriber receives are eligible for Benefits under the Contract. At the time the Subscriber's claims are submitted, they will be reviewed in accordance with the terms of the Contract.

PREEXISTING CONDITION

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A Preexisting Condition does not include pregnancy, nor can it be applied to a newborn or adopted child under age 18, as long as the child became covered under the Certificate within 31 days of birth or adoption.

PREEXISTING CONDITION EXCLUSION

A 12-month or 18-month period during which no Benefits will be provided for a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the Enrollment Date.

PRESCRIPTION DRUG

A medicinal substance required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal Law prohibits dispensing without a prescription."

PROPERLY FILED CLAIM

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider's itemized statement of services rendered and related charges; and medical records, when requested by the Plan.

PROVIDER

A Hospital, Physician, or other practitioner or Provider of medical services or supplies licensed to render Covered Services and performing within the scope of such license.

QUALIFYING EVENT

Any one of the following events which, but for the COBRA Continuation Coverage provisions of this Certificate, would result in the loss of a Subscriber's coverage:

- The death of the covered Employee;
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;
- A Dependent child ceasing to be eligible as defined under the Contract.

REGISTERED NURSE (RN)

A licensed nurse with a degree from a school of nursing.

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Subscriber.

SEVERE MENTAL ILLNESS

Any of the following biologically based Mental Illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- schizophrenia;
- bipolar disorder (manic-depressive illness);

- major depressive disorder;
- panic disorder;
- obsessive–compulsive disorder; and
- schizoaffective disorder.

SIGNIFICANT BREAK IN COVERAGE

A period of 63 consecutive days during all of which the individual did not have any Creditable Coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break In Coverage.

SKILLED NURSING FACILITY

A Provider which mainly provides Inpatient skilled nursing and related services to patients who need skilled nursing services around the clock but who do not need acute care in a Hospital bed. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Custodial Care, ambulatory, or part–time care; or
- Treatment for Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

SPECIAL ENROLLMENT PERIOD

A period during which an individual who previously declined coverage is allowed to Enroll under the Contract without having to wait until the Group's next regular Open Enrollment Period.

STOP–LOSS LIMIT

A specified dollar amount of Covered Services which are reimbursed at less than 100% of the Allowable Charge to or on behalf of a Subscriber during a Benefit Period. When the Stop–Loss Limit is reached, the level of Benefits is increased as specified in the ***Schedule of Benefits.***

SUBSCRIBER

The Member and each of his or her Dependents (if any) covered under this Certificate.

SURGERY

- The performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Usual and related preoperative and postoperative care.

THERAPY SERVICE

The following services and supplies ordered by a Physician when used to treat and promote your recovery from an illness or injury:

- **Radiation Therapy** — the treatment of disease by x–ray, radium, or radioactive isotopes.
- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High–Dose Chemotherapy. High–Dose Chemotherapy is specifically addressed in certain sections under ***"Human Organ, Tissue and Bone Marrow Transplant Services."***
- **Respiratory Therapy** — introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** — the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

- **Physical Therapy** — the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

- **Occupational Therapy** — treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

- **Speech Therapy** — treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

TOTAL DISABILITY (OR TOTALLY DISABLED)

A condition resulting from disease or injury in which, as certified by a Physician:

- The Subscriber is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Subscriber is not in fact engaged in any occupation for wages or profit; or

- If the Subscriber does not usually work for wages or profit, the Subscriber cannot do the normal activities of a person of the same age and sex.

The Plan reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan will make the final determination as to whether the Subscriber is Totally Disabled.

WAITING PERIOD

The period that must pass before an Eligible Person or Dependent is eligible to Enroll under the terms of a Group Health Plan. If an Eligible Person or Dependent Enrolls as a Late Enrollee or during a Special Enrollment Period, any period before such late or special enrollment is not a Waiting Period.

GF Group

BlueCross BlueShield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Certificate of Benefits to which this amendment is issued for attachment is amended as set forth below:

A. AMENDMENT RESPECTING CONVERSION PRIVILEGE

The *"Conversion Privilege After Termination of Group Coverage"* provisions of the Group Health Plan are hereby removed and shall no longer apply to any Subscriber.

B. AMENDMENT RESPECTING PSYCHIATRIC CARE SERVICES

The Benefits for "Psychiatric Care Services" are hereby deleted and replaced by the following:

PSYCHIATRIC CARE SERVICES

All Inpatient services and certain Outpatient services are subject to the *"Preauthorization"* requirements set forth in the *Important Information* section of this Certificate. If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.

We pay the scheduled amounts for the following Covered Services you receive from a Provider to treat Mental Illness:

- Inpatient Facility Services

  Covered Inpatient Hospital Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider (including partial hospitalization programs).

- Inpatient Medical Services

  Covered Inpatient Medical Services provided by a Physician or other Provider:

  - Medical Care visits limited to one visit or other service per day;
  - Individual Psychotherapy;
  - Group Psychotherapy;
  - Psychological Testing; and
  - Convulsive Therapy Treatment.

    Electroshock treatment or convulsive drug therapy including anesthesia when rendered together with treatment by the same Physician or other Provider.

  Benefits will not be provided for both an Inpatient Medical Care visit and Individual Psychotherapy when performed on the same day by the same Physician.

- Outpatient Psychiatric Care Services

  Covered Inpatient Facility and Medical Services when provided for the Outpatient treatment of Mental Illness by a Hospital, Psychiatric Hospital, Residential Treatment Center, Physician, or other Plan-approved Provider.

EXHIBIT 3 TO PLAINTIFF'S ORIGINAL PETITION

BCBSOK has omitted Exhibit 3 to Plaintiff's original Petition due to confidentiality